
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 13-02313-310**

# Combined Assessment Program Review of the Amarillo VA Health Care System Amarillo, Texas

**September 13, 2013**

**Washington, DC 20420**

**To Report Suspected Wrongdoing in VA Programs and Operations**
**Telephone: 1-800-488-8244**
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**(Hotline Information: www.va.gov/oig/hotline)**

# Glossary

| | |
|---|---|
| CAP | Combined Assessment Program |
| CLC | community living center |
| CS | controlled substances |
| EHR | electronic health record |
| EOC | environment of care |
| facility | Amarillo VA Health Care System |
| FPPE | Focused Professional Practice Evaluation |
| FY | fiscal year |
| HPC | hospice and palliative care |
| MEC | Medical Executive Committee |
| NA | not applicable |
| NC | noncompliant |
| OIG | Office of Inspector General |
| PCCT | Palliative Care Consult Team |
| QM | quality management |
| RME | reusable medical equipment |
| SPS | Sterile Processing Service |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

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# Executive Summary

**Review Purpose:** The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care. We conducted the review the week of July 8, 2013.

**Review Results:** The review covered six activities. We made no recommendations in the following activity:

- Medication Management – Controlled Substances Inspections

**Recommendations:** We made recommendations in the following five activities:

*Quality Management:* Ensure that senior leaders routinely discuss the facility's Inpatient Evaluation Center data and that the discussions are documented. Report results of completed Focused Professional Practice Evaluations for newly hired independent practitioners to the Medical Executive Committee. Revise the local observation bed policy to include all required elements. Establish a policy that defines Special Care Committee responsibilities. Include all services in the review of electronic health record quality. Ensure the blood usage and review process includes all required elements.

*Environment of Care:* Ensure that medications are secured at all times and that only pharmaceutical items are stored in medication refrigerators.

*Coordination of Care – Hospice and Palliative Care:* Include an assigned administrative support person on the Palliative Care Consult Team. Complete interdisciplinary care plans and Hospice/End of Life Care Plans for all hospice and palliative care inpatients. Screen all hospice and palliative care inpatients for advance directives upon admission.

*Pressure Ulcer Prevention and Management:* Accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers. Perform and document daily skin inspections and/or daily risk scales for patients at risk for or with pressure ulcers. Establish ongoing staff pressure ulcer education requirements.

*Nurse Staffing:* Monitor the staffing methodology that was implemented in December 2012.

## Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and

provided acceptable improvement plans. (See Appendixes C and D, pages 15–21, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

# Objective and Scope

## Objective

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objective of the CAP review is to conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.

## Scope

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following six activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Pressure Ulcer Prevention and Management
- Nurse Staffing

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2012 and FY 2013 through July 8, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Amarillo VA Health Care System, Amarillo, Texas,* Report No. 09-02264-225, September 22, 2009).

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 272 responded. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

# Results and Recommendations

## QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

| NC | Areas Reviewed | Findings |
|---|---|---|
| | There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members. | |
| X | There was evidence that Inpatient Evaluation Center data was discussed by senior managers. | Twelve months of MEC meeting minutes reviewed:<br>• There was no evidence that Inpatient Evaluation Center data was discussed. |
| | Corrective actions from the protected peer review process were reported to the Peer Review Committee. | |
| X | FPPEs for newly hired licensed independent practitioners complied with selected requirements. | Ten profiles reviewed:<br>• None of the FPPE results were reported to the MEC. |
| X | Local policy for the use of observation beds complied with selected requirements. | Facility policy reviewed and did not include:<br>• How the service or the physician responsible for the patient was determined<br>• That each admission must have a limited severity of illness<br>• Assessment expectations |
| | Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization. | |
| | Staff performed continuing stay reviews on at least 75 percent of patients in acute beds. | |
| | Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery. | |

| NC | Areas Reviewed (continued) | Findings |
|---|---|---|
| X | The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted. | Six months of Special Care Committee meeting minutes reviewed:<br>• There was no policy defining the responsibilities of the committee.<br>• There was no evidence that the committee reviewed each code episode.<br>• There was no evidence that the committee collected data that measured the performance in responding to resuscitation episodes. |
| X | There was an EHR quality review committee, and the review process complied with selected requirements. | Ten months of EHR Committee meeting minutes reviewed:<br>• Not all services were included in EHR quality reviews. |
| | The EHR copy and paste function was monitored. | |
| | Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs. | |
| X | Use and review of blood/transfusions complied with selected requirements. | Three quarters of Blood Usage Review Committee meeting minutes reviewed:<br>• The review process did not include the results of proficiency testing, of peer reviews, or of inspections by government or private (peer) entities**.** |
| | CLC minimum data set forms were transmitted to the data center with the required frequency. | |
| | Overall, if significant issues were identified, actions were taken and evaluated for effectiveness. | |
| | There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated. | |
| | Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months. | |
| | Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months. | |
| | The facility complied with any additional elements required by VHA or local policy. | |

## Recommendations

**1.** We recommended that senior leaders routinely discuss the facility's Inpatient Evaluation Center data and ensure the discussions are documented in the minutes of a senior-level committee.

**2.** We recommended that processes be strengthened to ensure that results of completed FPPEs for newly hired licensed independent practitioners are reported to the MEC.

**3.** We recommended that the local observation bed policy be revised to include how the service or the physician responsible for the patient is determined, that each admission must have a limited severity of illness, and assessment expectations.

**4.** We recommended that the facility establish a policy that defines Special Care Committee responsibilities, including code episode reviews and data collection.

**5.** We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

**6.** We recommended that processes be strengthened to ensure that the blood usage and review process includes the results of proficiency testing, of peer reviews, and of inspections by government or private (peer) entities.

## EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements and whether selected requirements in the hemodialysis and SPS areas were met.[2]

We inspected all inpatient units (medical/surgical, CLC, and intensive care), primary and specialty care outpatient clinics, the emergency department, and SPS. Additionally, we reviewed relevant documents, conversed with key employees and managers, and reviewed 16 employee training and competency files (10 operating room and 6 SPS). The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

| NC | Areas Reviewed for General EOC | Findings |
|---|---|---|
| | EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure. | |
| | An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas. | |
| | Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data. | |
| | Fire safety requirements were met. | |
| | Environmental safety requirements were met. | |
| | Infection prevention requirements were met. | |
| X | Medication safety and security requirements were met. | • There were unsecured medications in two of the eight areas inspected.<br>• There were food items stored in the medication refrigerator in two of the eight areas inspected. |
| | Sensitive patient information was protected, and patient privacy requirements were met. | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |
| | **Areas Reviewed for Hemodialysis** | |
| NA | The facility had policy detailing the cleaning and disinfection of hemodialysis equipment and environmental surfaces and the management of infection prevention precautions patients. | |

| NC | Areas Reviewed for Hemodialysis (continued) | Findings |
|---|---|---|
| NA | Monthly biological water and dialysate testing was conducted and included required components, and identified problems were corrected. | |
| NA | Employees received training on bloodborne pathogens. | |
| NA | Employee hand hygiene monitoring was conducted, and any needed corrective actions were implemented. | |
| NA | Selected EOC/infection prevention/safety requirements were met. | |
| NA | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |
| | **Areas Reviewed for SPS/RME** | |
| | The facility had policies/procedures/guidelines for cleaning, disinfecting, and sterilizing RME. | |
| | The facility used an interdisciplinary approach to monitor compliance with established RME processes, and RME-related activities were reported to an executive-level committee. | |
| | The facility had policies/procedures/guidelines for immediate use (flash) sterilization and monitored it. | |
| | Employees received required RME training and competency assessment. | |
| | Operating room employees who performed immediate use (flash) sterilization received training and competency assessment. | |
| | RME standard operating procedures were consistent with manufacturers' instructions, procedures were located where reprocessing occurs, and sterilization was performed as required. | |
| | Selected infection prevention/environmental safety requirements were met. | |
| | Selected requirements for SPS decontamination and sterile storage areas were met. | |
| | The facility complied with any additional elements required by VHA, local policy, or other regulatory standards. | |

## Recommendation

**7.** We recommended that processes be strengthened to ensure that medications are secured at all times and only pharmaceutical items are stored in medication refrigerators and that compliance be monitored.

## Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of the CS Coordinator and 10 CS inspectors and inspection documentation from 10 CS areas, the inpatient and outpatient pharmacies, and the emergency drug cache. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

| NC | Areas Reviewed | Findings |
|---|---|---|
| | Facility policy was consistent with VHA requirements. | |
| | VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected. | |
| | Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed. | |
| | Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director. | |
| | CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest. | |
| | CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest. | |
| | Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements. | |
| | Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements. | |
| | The facility complied with any additional elements required by VHA or local policy. | |

## Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 20 EHRs of patients who had PCCT consults (including 10 HPC inpatients), and 25 employee training records (10 HPC staff records and 15 non-HPC staff records), and we conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

| NC | Areas Reviewed | Findings |
|---|---|---|
| X | A PCCT was in place and had the dedicated staff required. | List of staff assigned to the PCCT reviewed:<br>• An administrative support person had not been assigned to the PCCT. |
| | The PCCT actively sought patients appropriate for HPC. | |
| | The PCCT offered end-of-life training. | |
| | HPC staff and selected non-HPC staff had end-of-life training. | |
| | The facility had a VA liaison with community hospice programs. | |
| | The PCCT promoted patient choice of location for hospice care. | |
| NA | The CLC-based hospice program offered bereavement services. | |
| | The HPC consult contained the word "palliative" or "hospice" in the title. | |
| | HPC consults were submitted through the Computerized Patient Record System. | |
| | The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon. | |
| | Consult responses were attached to HPC consult requests. | |
| | The facility submitted the required electronic data for HPC through the VHA Support Service Center. | |
| X | An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe. | • Two care plans were not completed after the patients were transferred to hospice. |
| | HPC inpatients were assessed for pain with the frequency required by local policy. | |
| | HPC inpatients' pain was managed according to the interventions included in the care plan. | |

| NC | Areas Reviewed (continued) | Findings |
|---|---|---|
| X | HPC inpatients were screened for an advanced directive upon admission and according to local policy. | • Two of the eight EHRs of inpatients able to communicate did not contain documentation of advance directive screening upon admission. |
| X | The facility complied with any additional elements required by VHA or local policy. | Facility policy on end-of-life care planning for inpatient and outpatient hospice care reviewed:<br>• None of the EHRs contained a Hospice/End of Life Care Plan. |

## Recommendations

**8.** We recommended that processes be strengthened to ensure that the PCCT includes an assigned administrative support person.

**9.** We recommended that processes be strengthened to ensure that interdisciplinary care plans are completed for all HPC inpatients.

**10.** We recommended that processes be strengthened to ensure that advance directive screening is performed upon admission for all HPC inpatients.

**11.** We recommended that processes be strengthened to ensure that a Hospice/End of Life Care Plan is completed for all HPC inpatients.

## Pressure Ulcer Prevention and Management

The purpose of this review was to determine whether acute care clinicians provided comprehensive pressure ulcer prevention and management.[5]

We reviewed relevant documents, 8 EHRs of patients with pressure ulcers (5 patients with hospital-acquired pressure ulcers, 2 patients with community-acquired pressure ulcers, and 1 patient with pressure ulcers at the time of our onsite visit), and 10 employee training records. Additionally, we inspected one patient room. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

| NC | Areas Reviewed | Findings |
|---|---|---|
| | The facility had a pressure ulcer prevention policy, and it addressed prevention for all inpatient areas and for outpatient care. | |
| | The facility had an interprofessional pressure ulcer committee, and the membership included a certified wound care specialist. | |
| | Pressure ulcer data was analyzed and reported to facility executive leadership. | |
| | Complete skin assessments were performed within 24 hours of acute care admissions. | |
| | Skin inspections and risk scales were performed upon transfer, change in condition, and discharge. | |
| X | Staff were generally consistent in documenting location, stage, risk scale score, and date acquired. | • In seven of the eight EHRs, staff did not consistently document the location, stage, risk scale score, and/or date acquired. |
| X | Required activities were performed for patients determined to be at risk for pressure ulcers and for patients with pressure ulcers. | • Four of the eight EHRs did not contain consistent documentation that staff performed daily skin inspections and/or daily risk scales. |
| | Required activities were performed for patients determined to not be at risk for pressure ulcers. | |
| | For patients at risk for and with pressure ulcers, interprofessional treatment plans were developed, interventions were recommended, and EHR documentation reflected that interventions were provided. | |
| | If the patient's pressure ulcer was not healed at discharge, a wound care follow-up plan was documented, and the patient was provided appropriate dressing supplies. | |

| NC | Areas Reviewed (continued) | Findings |
|---|---|---|
| | The facility defined requirements for patient and caregiver pressure ulcer education, and education on pressure ulcer prevention and development was provided to those at risk for and with pressure ulcers and/or their caregivers. | |
| X | The facility defined requirements for staff pressure ulcer education, and acute care staff received training on how to administer the pressure ulcer risk scale, conduct the complete skin assessment, and accurately document findings. | • The facility had not developed ongoing staff pressure ulcer education requirements. |
| | The facility complied with selected fire and environmental safety, infection prevention, and medication safety and security requirements in pressure ulcer patient rooms. | |
| | The facility complied with any additional elements required by VHA or local policy. | |

## Recommendations

**12.** We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

**13.** We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections and/or daily risk scales for patients at risk for or with pressure ulcers and that compliance be monitored.

**14.** We recommended that the facility establish ongoing staff pressure ulcer education requirements and that compliance be monitored.

## Nurse Staffing

The purpose of this review was to determine the extent to which the facility implemented the staffing methodology for nursing personnel and to evaluate nurse staffing on three inpatient units (acute medical/surgical, long-term care, and mental health).[6]

We reviewed relevant documents and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Any items that did not apply to this facility are marked NA.

| NC | Areas Reviewed | Findings |
|---|---|---|
| X | The facility completed the required steps to develop a nurse staffing methodology by the deadline. | • Expert panels were not convened until December 19, 2012. |
| NA | The unit-based expert panels followed the required processes and included all required members. | |
| NA | The facility expert panel followed the required processes and included all required members. | |
| NA | Members of the expert panels completed the required training. | |
| NA | The actual nursing hours per patient day met or exceeded the target nursing hours per patient day. | |
| NA | The facility complied with any additional elements required by VHA or local policy. | |

### Recommendation

**15.** We recommended that nursing managers monitor the staffing methodology that was implemented in December 2012.

| Facility Profile (Amarillo/504) FY 2013 through May 2013[a] | |
|---|---|
| **Type of Organization** | Secondary |
| **Complexity Level** | 2-Medium complexity |
| **Affiliated/Non-Affiliated** | Affiliated |
| **Total Medical Care Budget in Millions** | $166.7 |
| **Number (through June 2013) of:** | |
| • **Unique Patients** | 22,783 |
| • **Outpatient Visits** | 174,324 |
| • **Unique Employees**[b] | 1,019 |
| **Type and Number of Operating Beds:** | |
| • **Hospital** | 44 |
| • **CLC** | 120 |
| • **Mental Health** | NA |
| **Average Daily Census:** | |
| • **Hospital** | 26 |
| • **CLC** | 114 |
| • **Mental Health** | NA |
| **Number of Community Based Outpatient Clinics** | 4 |
| **Location(s)/Station Number(s)** | Lubbock, TX/504BY<br>Clovis, NM/504BZ<br>Childress, TX/504GA<br>Stratford, TX/504HB |
| **VISN Number** | 18 |

[a] All data is for FY 2013 through May 2013 except where noted.
[b] Unique employees involved in direct medical care (cost center 8200).

# VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient scores for quarters 3–4 of FY 2012 and quarters 1–2 of FY 2013 and overall outpatient satisfaction scores for FY 2012.

**Table 1**

| | Inpatient Scores | | Outpatient Scores | | | |
|---|---|---|---|---|---|---|
| | FY 2012 | FY 2013 | FY 2012 | | | |
| | Inpatient Score Quarters 3–4 | Inpatient Score Quarters 1–2 | Outpatient Score Quarter 1 | Outpatient Score Quarter 2 | Outpatient Score Quarter 3 | Outpatient Score Quarter 4 |
| Facility | 70.0 | 70.8 | 60.5 | 53.7 | 56.9 | 56.8 |
| VISN | 66.7 | 64.9 | 51.1 | 52.5 | 49.9 | 53.3 |
| VHA | 65.0 | 65.5 | 55.0 | 54.7 | 54.3 | 55.0 |

# Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.[c] Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are "risk-adjusted" to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2008, and June 30, 2011.[d]

**Table 2**

| | Mortality | | | Readmission | | |
|---|---|---|---|---|---|---|
| | Heart Attack | Heart Failure | Pneumonia | Heart Attack | Heart Failure | Pneumonia |
| Facility | 15.4 | 11.1 | 12.6 | 18.8 | 24.1 | 18.8 |
| U.S. National | 15.5 | 11.6 | 12.0 | 19.7 | 24.7 | 18.5 |

[c] A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Heart failure is a weakening of the heart's pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

[d] Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** August 27, 2013

**From:** Director, VA Southwest Health Care Network (10N18)

**Subject:** **CAP Review of the Amarillo VA Health Care System, Amarillo, TX**

**To:** Director, San Diego Office of Healthcare Inspections (54SD)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. I have reviewed and concur with the findings and recommendations in the report of the Combined Assessment Program Review of the Amarillo VA Health Care System, Amarillo, Texas.

2. If you have any questions or concerns, please contact Sally Compton, Executive Assistant to the Network Director, VISN 18, at 602-222-2699.

Susan P. Bowers

# Facility Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** August 26, 2013

**From:** Director, Amarillo VA Health Care System (504/00)

**Subject:** **CAP Review of the Amarillo VA Health Care System, Amarillo, TX**

**To:** Director, VA Southwest Health Care Network (10N18)

Thank you for the opportunity to review the draft report of recommendations from the OIG CAP conducted at the Amarillo VA Health Care System. We have reviewed the report from the site visit and concur with the recommendations; corrective action plans with target dates for completion are attached.

Thank you,

Andrew M. Welch, MHA, FACHE

# Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

**OIG Recommendations**

**Recommendation 1.** We recommended that senior leaders routinely discuss the facility's Inpatient Evaluation Center data and ensure the discussions are documented in the minutes of a senior-level committee.

Concur

Target date for completion: December 31, 2013

Facility response:

Amarillo VAHCS leadership will discuss IPEC data once a quarter at the Performance Improvement Committee (PIC). Minutes of the PIC meeting will include a summary and/or identified trends of all IPEC components discussed.

**Recommendation 2.** We recommended that processes be strengthened to ensure that results of completed FPPEs for newly hired licensed independent practitioners are reported to the MEC.

Concur

Target date for completion: October 31, 2013

Facility response:

To ensure that processes are strengthened for reporting of results of completed FPPEs for newly hired licensed independent practitioners to the Medical Executive Committee (MEC), monthly minutes of MEC will include an individual list of completed FPPEs. A tracking mechanism has been developed to ensure FPPEs are initiated and completed for all newly hired physicians. Results of FPPEs as well as the number of FPPEs completed versus number of newly hired physicians will be reported to Medical Executive Committee on monthly basis.

**Recommendation 3.** We recommended that the facility's observation bed policy be revised to include how the service or the physician responsible for the patient is determined, that each admission must have a limited severity of illness, and assessment expectations.

Concur

Target date for completion: August 15, 2013

Facility response:

The revised Medical Center Policy on Observation Admissions includes all appropriate elements from the VHA Directive 2010-011: Standards for Emergency Departments, Urgent Care Clinics and Facility Observation Beds. The new Policy was signed August 8, 2013.

**Recommendation 4.** We recommended that the facility establish a policy that defines Special Care Committee responsibilities, including code episode reviews and data collection.

Concur

Target date for completion: November 30, 2013

Facility response:

The Special Care Committee has revised the minutes to include a standing agenda item for the review of cardiopulmonary resuscitation events. The minutes will include an analysis of the aggregated data for all the required review elements, which includes the screening for clinical issues prior to the event. A new policy which is being developed will define the responsibilities of the committee; and assigns a cardiac nurse specialist to collect and review all code episodes. The monthly data results will be reported to the Special Care Committee.

**Recommendation 5.** We recommended that processes be strengthened to ensure that the review of EHR quality includes all services.

Concur

Target date for completion: November 30, 2013

Facility response:

The Chairman of the Record of Care Committee (ROC) will send a memo out to all Clinical Service Chiefs requiring electronic health record (EHR) point of care (POC) quality reviews within their service. The POC EHR reviews will be reported to the ROC committee monthly. The committee will monitor EHR indicators for each clinical service. Monitoring and analysis of the POC EHR quality reviews will be reflected in the monthly minutes.

**Recommendation 6.** We recommended that processes be strengthened to ensure that the blood usage and review process includes the results of proficiency testing, of peer reviews, and of inspections by government or private (peer) entities.

Concur

Target date for completion: November 30, 2013

Facility response:

To ensure that blood usage and review process includes the results of proficiency testing; of peer reviews; and, of inspections by government or private (peer) entities, these elements were added to the standing agenda items for the Blood Usage Review Committee Meeting.

**Recommendation 7.** We recommended that processes be strengthened to ensure that medications are secured at all times and only pharmaceutical items are stored in medication refrigerators and that compliance be monitored.

Concur

Target date for completion: November 30, 2013

Facility response:

Medication refrigerator audits have been added as a standing audit item to the Environment of Care rounds and will be added to the Medication Management Committee monthly meeting. Any specific incidents of medication refrigerator issues will be addressed with the nurse manager and corrected immediately.

**Recommendation 8.** We recommended that processes be strengthened to ensure that the PCCT includes an assigned administrative support person.

Concur

Target date for completion: September 16, 2013

Facility response:

A dedicated medical service staff person will be assigned 10 hours a week for administrative support (0.25 FTEE) for the PCCT program.

**Recommendation 9.** We recommended that processes be strengthened to ensure that interdisciplinary care plans are completed for all HPC inpatients.

Concur

Target date for completion: April 14, 2014

Facility response:

Hospice/Palliative Interdisciplinary care plans are being defined and the SOP will be completed by September 30, 2013. Monthly monitoring for completion of care plans will be compiled by the HPC Coordinator and reported monthly to the Performance Improvement Committee. Monitoring will continue for two quarters to ensure compliance.

**Recommendation 10.** We recommended that processes be strengthened to ensure that advance directive screening is performed upon admission for all HPC inpatients.

Concur

Target date for completion: April 14, 2014

Facility response:

To strengthen processes to ensure advance directive screening is performed upon admission or transferred for all HPC inpatients, an Advance Directive consult will be entered on all patients admitted to HPC. The Hospice Coordinator will review all new admissions for advanced directives by the next business day. Monitoring for timeliness of submission of the consult, and completed within 24 hours of admission with a target of 90% compliance will be reported monthly to the Performance Improvement Committee and monitoring will continue for two quarters to ensure compliance.

**Recommendation 11.** We recommended that processes be strengthened to ensure that a Hospice/End of Life Care Plan is completed for all HPC inpatients.

Concur

Target date for completion: April 14, 2014

Facility response:

To ensure that processes are strengthened to ensure a Hospice/End-of-Life Care Plan is completed for all HPC inpatients, the Hospice Coordinator will audit all new admissions for completion of a care plan. The Hospice End of Life Treatment MCM is being revised which will define the End of Life Care Plan and will replace the ITP. Monthly monitoring for completion of care plans will be compiled by the HPC Coordinator and reported monthly to the Performance Improvement Committee. Monitoring will continue for two quarters to ensure compliance.

**Recommendation 12.** We recommended that processes be strengthened to ensure that acute care staff accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: November 30, 2013

Facility response:

In order to ensure acute care staff accurately document location, stage, risk scale score, and date pressure ulcer is acquired, a Wound Documentation Template is being added to the skin assessment/reassessment progress note. This template requires authors to

address specific wound characteristics as outlined by the VA Directive. Nurse Managers will monitor compliance and report monthly findings to Quality Management.

**Recommendation 13.** We recommended that processes be strengthened to ensure that acute care staff perform and document daily skin inspections and/or daily risk scales for patients at risk for or with pressure ulcers and that compliance be monitored.

Concur

Target date for completion: November 30, 2013

Facility response:

To ensure that acute care staff perform and document daily skin inspections and/or daily risk scales for patients at risk or with pressure ulcers, the requirement of physical assessments and skin assessments have been changed in frequency from daily to every shift. Nurse Managers will monitor compliance and report monthly findings to Quality Management.

**Recommendation 14.** We recommended that the facility establish ongoing staff pressure ulcer education requirements and that compliance be monitored.

Concur

Target date for completion: November 30, 2013

Facility response:

New pressure ulcer education modules have been developed and inpatient clinical nursing staff is required to complete the training by November 30, 2013. These modules will be included in the future as mandatory annual education for inpatient clinical nursing staff beginning in FY 2014.

**Recommendation 15.** We recommended that nursing managers monitor the staffing methodology that was implemented in December 2012.

Concur

Target date for completion: September 30, 2013

Facility response:

As of June 30, 2013, all Unit Based Expert Panels are in place to review staffing methodology. Recommendations from the panels are presented to the Facility Staffing Methodology Expert Panel. Minutes and recommendations from this panel are submitted to the NE/ADPCS on a monthly basis.

# OIG Contact and Staff Acknowledgments

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|---|---|
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# Endnotes

[1] References used for this topic included:
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